



File # _____
Fund Use Only

**TRAUMATIC BRAIN INJURY FUND
MEDICAL DOCUMENTATION FORM**

Please bring this form to your doctor for completion and return it with your application. This form must be completed and signed by a licensed medical doctor ONLY (i.e. primary care doctor; neurologist, etc.).

SECTION I: TO BE COMPLETED BY APPLICANT OR GUARDIAN

APPLICANT'S NAME _____

APPLICANT'S ADDRESS _____

APPLICANT'S PHONE NUMBER _____

CONTACT PERSON _____

(i.e. anyone other than the applicant with whom we should speak)

I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and I understand that medical information will be protected under the Health Insurance Portability and Accountability Act (HIPAA).

SIGNATURE OF APPLICANT OR GUARDIAN:

DATE: _____

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SECTION II:

TO BE COMPLETED BY MEDICAL DOCTOR ONLY

N.J.A.C. 10:141, the statute that regulates the Traumatic Brain Injury Fund, utilizes the following definition of brain injury:

"Traumatic brain injury" means an acquired injury to the brain. This term does not include brain dysfunction caused by congenital or degenerative disorders or birth trauma, but may include injuries caused by anoxia due to trauma.

In your professional medical opinion, does the applicant's diagnosis meet this definition?

YES NO

Please explain:

Nature of brain injury (i.e. stroke, traumatic brain injury, anoxia, etc.):

Circumstance of brain injury (i.e. arteriovenous malformation, motor vehicle accident, etc.):

Will this condition require ongoing treatment and support?

YES NO

Please explain:

Are there other medical conditions that have arisen as a direct result of the brain injury?

What brain injury related supports and/or services would you like to recommend at this time, if any (i.e. cognitive therapy, adaptive equipment, physical therapy, etc.)? Please note that a case manager may contact you for prescriptions and/or clarification regarding these supports and/or services.

SECTION III: DOCTOR'S CONTACT INFORMATION

Name (printed) _____

Name (signed) _____

Address _____

Phone Number _____

Fax Number _____

If you have any questions regarding this form, please call Amy Taklif, TBI Specialist, at 888-285-3036 (press 2).

Please return completed application to:
TBI Fund
NJ Division of Disability Services
PO Box 700
Trenton, NJ 08625

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